

FILED JAN 27 1951

STANDARD CERTIFICATE OF DEATH

State File No. 43644

BIRTH NO. REG. DIST. NO. 2-198 PRIMARY REG. DIST. NO. 4310 Registrar's No. 94

1. PLACE OF DEATH
a. COUNTY Macon
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Bevier
c. LENGTH OF STAY (in this place) 52 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 207 N. Linn

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Mo. b. COUNTY Macon
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Bevier 0610
d. STREET ADDRESS (If rural, give location) 207 N Linn 0

3. NAME OF DECEASED
a. (First) Elizabeth b. (Middle) V. c. (Last) Thomas

4. DATE OF DEATH (Month) (Day) (Year) Nov. 12 1950

5. SEX Female
6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH Nov. 13, 1869

9. AGE (In years) (Months) (Days) (Hours) (Min.) 80

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Wales. 4

12. CITIZEN OF WHAT COUNTRY? U.S.A

13a. FATHER'S NAME David M. Evans

13b. MOTHER'S MAIDEN NAME Sarah Owen

14. NAME OF HUSBAND OR WIFE John V. Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. None

17. INFORMANT'S SIGNATURE OR NAME Mrs. W. D. Nichols ADDRESS Bevier Mo.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure 1 yr
(+) General Arterio-sclerotic disease
ANTECEDENT CAUSES
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) _____
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH
4200

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION
EROT + 90%

20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. CITY, TOWN OR TOWNSHIP (COUNTY) (STATE)
Bevier Macon Mo.

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR

22. I hereby certify that I attended the deceased from Oct 15, 1950 to Nov 12, 1950, that I last saw the deceased alive on Nov 12, 1950 and that death occurred at 3:32 p.m., from the causes and on the date stated above.

23a. SIGNATURE J. P. Inourey M.D. (Degree or title)

23b. ADDRESS Bevier Mo.

23c. DATE SIGNED Nov 12/30/50

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 11/14/50

24c. NAME OF CEMETERY OR CREMATORY West Oakwood

24d. LOCATION (City, town, or county) (State) Bevier Mo.

DATE REC'D BY LOCAL REG. 1/2/51

REGISTRAR'S SIGNATURE Josephine King 397

25. FUNERAL DIRECTOR'S SIGNATURE Albert Keiser ADDRESS Macon Mo.

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

610
1

RECEIVED 1-25-51
MACON COUNTY HEALTH DEPARTMENT
County File No. 1-51-11
Date Filed 1-26-51

Date Received: JAN 8 1951
DISTRICT HEALTH OFFICE #2
~~Date Filed: _____~~
~~District File Number _____~~

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

working under my personal supervision.

Student Embalmer No.

Signed Albert Skinner

Signed.....
Student Embalmer

Licensed Embalmer No. 757

P. O. Address Macon

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.